State Innovation Models:
Round Two of Funding for Design and Test Assistance
Funding Opportunity Number: CMS-1G1-14-001
Budget Negotiation – Programmatic Questions

State	Connecticut
Applicant	Office of the Healthcare Advocate
Application #	1G12014000289
Type of Award Sought	Model Test
Amount Requested	Federal: $63,725,086

We have conducted a thorough programmatic and financial review of your Model Testing application. We have several outstanding questions, requests for clarification and budgetary issues that are listed below. You may use this document to provide your response – please include your answer immediately following each question. In addition, please complete the informational tables at the end of this document and submit a revised Financial Plan and SF424a. You do not need to resubmit any other parts of your application unless we specifically ask you to do so.

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1. Page 3 of the FOA states, "As a condition of the award, the state must commit to sustain its model after the design and/or test period." Further, stated on page 36, "States need to show how their models will be sustainable after the testing period is complete."

   Considering these requirements, please address the following:

   a) Describe the state's plan to sustain the innovation initiatives as described in your proposal, such as practice transformation support, beyond the SIM period of performance.

   See Pages 58 to 65 of the Revised Project Narrative.

   Response:

   Program Management Office: The annual insurance assessment upon which the Program Management Office (PMO) was established is ongoing and will continue to provide support for multi-payer alignment and the coordination of related initiatives. The SIM Governance Structure and the associated quality measure alignment, Value-based Insurance Design, and stakeholder engagement initiatives will be sustained after the performance period by means of the annual insurance assessment.

   The annual insurance assessment also includes a modest budget for practice transformation support, which we anticipate will be ongoing. The state is proposing to substantially supplement these practice transformation funds with the proposed SIM Model Test grant investments. In summer of 2018, the state will assess whether the state is achieving its projected goals, whether and to what extent practice transformations appear to be contributing to improvements in the state's performance, and the projected need for such support after the performance period. Based on the estimated need, the state will pursue an appropriation for additional state funding for the SFY20 and SFY21 biennium. The PMO will be responsible for bridge funding from the close of the performance period to the start of the SFY20/21 biennium. We do not currently plan to continue Innovation Awards beyond the performance period. Finally, the PMO budget includes funds to cover the ongoing costs for evaluation, which we intend to continue at reduced scope beyond the performance period.

Department of Public Health (DPH): The majority of the costs of implementing the Population Health plan are not included in our SIM Model Test grant request. Consequently, we intend to seek an appropriation for the SFY18/19 biennium and funding that might be available through other grant opportunities to cover the costs of implementing Health Enhancement Communities and other recommendations contained within our population health plan. The state will seek appropriations for an expansion of the Health Enhancement Community demonstration in future years if the anticipated benefits in health and costs are borne out in our evaluation. Sustainability can also be affected by strategic partnerships that may include philanthropies, private payers, or other entities that have interest and synergies. Once models are set up and evaluated, activities that enhance or improve capacity of the health system will be integrated at the state and community level, representing new and improved ways of doing business.

Department of Social Services (DSS) – Medicaid QISSP: The value of the Medicaid Quality Improvement and Shared Savings Program (QISSP) and multi-payer alignment will be assessed ongoing. Assuming favorable results, we anticipate that such programs would continue to align with the Medicare Share Savings Program (SSP) and subsequent iterations of this program. SIM grant funds will support the start-up and initial administrative costs associated with the Medicaid QISSP program. The costs of ongoing administration of the Medicaid QISSP will be accommodated within the overall Medicaid appropriation, to the extent that the program continues to have the desired impacts on the quality and efficiency of care.

DSS HIT: We estimate the Health Information Technology (HIT) infrastructure and operating costs between $3.6-4 million annually, including costs associated with support provided by the University of Connecticut Health Center (UCHC). After the SIM grant, these costs will be borne by the state (25%), Medicaid (25%), and Others (hospitals, FQHCs, ACOs, IPAs) to enhance and invest in the state HIT infrastructure for delivery of quality care.

Workforce: The following sustainability plan applies to workforce initiatives:

- Community Health Workers (CHW): SIM Test Grant funds will help develop and launch a CHW training and certification program. Department of Labor funds are already supporting the development and launch of the community college participation in the program. Once our overall program is firmly established, tuition will be charged for the courses, although we will seek grant funds from both private and public sources to subsidize tuition.

- Inter-professional Education (IPE): SIM Test Grant funds will help meet the development costs of coordinating all of the inclusion of all of Connecticut's health professions schools, and expanding our current urban IPE program (Urban Service Track) to cover disadvantaged populations throughout the state. Once our statewide program (i.e., Connecticut Service Track, see response to question 20) is established, participating health professions undergraduate and graduate programs will support the inclusion of their students and residents by paying for each student and resident to cover CST's costs per participant that are over and above in-kind contributions made by instructors, mentors and the institutions or providers that are venues for CST.

- Teaching Health Centers: SIM Test Grant funds will support the development and preparation of the Connecticut Teaching Center Coalition so that it can effectively seek support from HRSA's teaching health center program and also from private sources, such as the Macy and Pew foundations. Once our primary care residency programs are established, we expect them to be allocated GME slots and to be supported by GME funding.

b) Describe how the staffing level described in the proposal will be sustained after the SIM project period concludes.

See Pages 58 to 65 of the Revised Project Narrative.

Response:

Program Management Office: The legislature has established and allocated funding for nine positions in the PMO. SIM Test Grant funding will support an additional seven positions, with the following plan for sustainability:

- Research analyst – The test grant period will enable the state to establish a new relationship with UConn to design, test and implement rapid cycle evaluation methods and processes with our state agency and private payer partners. We believe that this position will not be needed after the test grant period with methods established and reduced scope evaluation activities.

- Practice transformation manager and 3 health program associates (HPAs) – The ongoing need for all of these positions will depend on the evaluation of practice transformation activities funded under the SIM test grant, and the extent to which there continues to be a need in the provider community for substantial assistance with practice transformation. If the scope of ongoing practice transformation activities warrants the continuation of one or more of these positions, funding will be sought through the appropriations process.

- Grants/contracts specialist – With the anticipated reduction in the scope of the PMO's work after the SIM grant, especially with respect to the number of contracts, we believe this position will no longer be necessary.

- Nurse consultant – The need for this position will be reassessed during the second implementation year and, if required, will be funded ongoing as part of the established PMO budget.

DPH – Population Health: As stated above in the response to 1a, the majority of the costs of implementing the Population Health Plan are not included in our SIM Model Test grant request. We intend to seek an appropriation for the SFY 18/19 biennium and other grant funding to cover the costs of implementing recommendations and associated staff critical to that activity. With respect to the Population Health Plan, critical staff for implementation includes the 9 positions requested for funding under the SIM Test Grant Application, as well as continuation of contractor ICF Macro that administers the BRFSS survey and enhanced sampling to support multi-year trend analysis for small area estimates on population subgroups.

DSS – Medicaid QISSP: SIM funded staffing support from the Department of Social Services includes a state-supported Health Program Assistant position. This position will be procured

through the typical civil service justification and recruitment process. This Health Program Assistant position will be assigned within the Department's Division of Health Services Integrated Care Unit. All other activity (e.g. relating to QISSP) will be performed in the early stages of the grant period by the Department's contractor, Mercer. Ongoing oversight of this shared savings initiative will reside within the Department's Divisions of Health Services and Finance, as well as be supported by the Department's medical Administrative Services Organization (ASO), Community Health Network (CHN). The required level of staffing will be re-assessed in SFY17 and an adjustment to the Department's appropriation will be sought as necessary.

The Department's Division of Financial Services will also require two positions to support QISSP. One of these positions, an Associate Accountant, will be assigned to work closely with the actuarial support consultant, Mercer, throughout the following range of activities: State and federal budget development and analyses; financial modeling of proposed shared savings arrangements; detailed development, review and maintenance of shared savings calculations; data review and analyses in support of financial modeling and budget activities; and financial support for contract development and monitoring activities. In addition, the Division of Financial Services will also require an Accountant position to meet the reporting requirements associated with the project. This position will also provide needed support to the above position to meet expected peak workload demands and other priority financial assignments related to the SIM.

DSS – HIT: UCHC staffing costs are among the overall HIT costs that we anticipate will be borne by the state (25%), Medicaid (25%), and Others (hospitals, FQHCs, ACOs, IPAs) after the conclusion of SIM funding.

c) In the Operational Plan section of your proposal, you indicate the proposed use of contractors to perform significant activity under this cooperative agreement. Describe the state's plan to integrate the contractors' work following the SIM period of performance.

See Pages 58 to 65 of the Revised Project Narrative.

Response:

Program Management Office: As noted earlier, the annual insurance assessment upon which the PMO was established is ongoing and will continue to provide support for the continuation of the SIM Governance Structure. Together, the SIM PMO and Governance structure provide the resources to support ongoing *coordination* of state agencies, payers, and various stakeholders, and the *integration* of the work of those contractors that continue beyond the period of performance.

The PMO is proposing to contract for practice transformation support (advanced medical home and community and clinical integration program) and evaluation services. After the performance period, the state intends to continue these contracts because the skills and expertise required of such contracts cannot be easily established and maintained within a state agency structure. Our intent is to use practice transformation vendors who have the capability to apply the state of the art in transformation support and process re-engineering. These are among the contracted supports (like our ASO model for Medicaid management) that do not lend themselves to incorporation into the state agency infrastructure. A similar strategy will be employed for evaluation services. We intend to continue to rely on the services of UConn or other academic or research partners with expertise in rapid cycle and program evaluation.

DPH: Contractors for Population Health (Macro International (BRFSS interviews), Demographic modeling (town level population estimates), and Population Health Plan Facilitation) require specialized skills, knowledge of content areas, and dedicated time to support development of the Population Health Plan. With the exception of Macro who is utilized on an ongoing basis, the consultants are short term and will not continue after the SIM Test period. The expected results are a Population Health Plan that will be implemented through multi-sector partnerships at the state and community level with coordination by dedicated SIM staff at DPH.

DPH will contract with the existing vendor (Macro) for BRFSS interviews and will seek a qualified demographer who can develop a methodology to generate valid population estimates by race and ethnicity for each of the 169 towns in Connecticut. The models developed for town level population estimates established by the demographics consultant will be implemented by the Epidemiologist3 position in future years. Along with the specific skills needed, current staffing levels at DPH do not allow for dedicated time to produce models and estimates. DPH will also seek capable vendors that have prior experience developing the state's Healthy Connecticut 2020 State Health Improvement Plan. In this way the contractor will have knowledge of Connecticut's structure and environment, experience working with sectors and partners involved in initial planning, and demonstrated skills in community engagement, facilitation of diverse groups discussing complex issues, and statewide health improvement planning

DSS – Medicaid QISSP: Actuarial and other staging work performed by contractor Mercer in support of the Medicaid QISSP will occur in the early stages of the grant period. Ongoing, oversight of the means and method of assessing eligibility for, as well as distributing, shared savings will reside in the Department of Social Services' Divisions of Health Services and Finance, and will be supported by the Department's medical ASO (CHN), and MMIS contractor (HP).

DSS (HIT): Most of the SIM HIT infrastructure costs are associated with the purchase and maintenance of technology. The state will continue to procure services from vendors that are relevant to the operations to support interoperability. We estimate HIT infrastructure and operating costs between $3.6-4 million annually. Finally, the state occasionally relies on agreements with UConn and UCHC to perform ongoing administrative functions that might otherwise reside within a state agency. UCHC personnel currently provide support to DSS related to the administration of the EHR incentive program, business intelligence competency center, and health information exchange. Accordingly, we anticipate that the support for SIM HIT initiatives that will be provided by UCHC personnel will be ongoing.

2. Page 3 of the FOA states, "funded proposals must articulate both a broad vision for state-wide health care transformation and describe ambitious, realizable programs in identified areas." Explain how the individual elements described in the proposal will scale to statewide implementation during the SIM period of performance. Include a timeline for scaling specific elements of the proposal.

See Page 65 of the Revised Project Narrative.

Response: All of the individual elements of our proposal are statewide as of the start of the period of performance (1/1/16), since none of the elements are geographically bounded and may involve providers and beneficiaries throughout the state. The exception is the model recommended as a result of our Population Health planning, which will not be substantially implemented until after the

SIM period of performance (January 1, 2019). Although there are no geographic boundaries for the elements of our model test, we will be undertaking a process to maximize statewide participation of providers and beneficiaries over the period of performance.

Plan for Improving Population Health	Planning for scale and statewide implementation for population health interventions will be incorporated into the population health planning process in years 1, 2 and 3. The Prevention Services Center demonstration phase will be evaluated in year 4 and key aspects of evaluation will focus on scalability elements (e.g. financing, staffing, and physical plant requirements, nature of relationship with AMHs). Health Enhancement Communities are envisioned as targeting areas in the state with highest disparity and are not proposed for scale or state-wide implementation during the SIM period of performance, nevertheless planning for scale will occur throughout the performance period (e.g. facilitated population health planning team meetings and/or workgroups specifically focused on scalability planning.
SSP payment reforms based on care experience and quality	This initiative begins statewide. Beneficiary participation is projected to scale to 64% by the end of the period of performance (2018) and to 85% by 2020 (see response to Question 7).
Medicaid QISSP/AMH/CCIP	The Medicaid QISSP, AMH and CCIP programs will be made available to providers statewide by competitive procurement with the first wave of participants to begin 2016. Beneficiary and provider participation in Medicaid QISSP will increase in two subsequent waves in 2018 and 2020, by which time participation should include the great majority of providers and Medicaid beneficiaries (90%) as illustrated in our response to Question 7.
Value-based Insurance Design	This initiative begins statewide. Beneficiary participation is projected to scale to nearly 85% by 2020 (see response to Question 7).
Quality Measure Alignment	This initiative begins statewide. Our goal is to implement quality measure alignment for all Advanced Networks in 2016, as well as those FQHCs participating in the Medicaid QISSP.
Workforce Development	Our workforce initiatives will support workforce development statewide.

3. Page 3 of the FOA states, "States may propose to use SIM funds for the implementation of specific technology, software, applications, or other analytical tools as part of state infrastructure development to support the Model Test as long as the state provides a clear strategy for how, if applicable, the technological approach will be financed in addition to SIM, how it will not supplant other funding sources, and how it will be sustained after the cooperative agreement period has ended."

a) Describe how the health IT investments described in the proposal will meet these conditions. Specifically, indicate how the SIM investments will align with statewide or regional HIE efforts to expand the availability and interoperability of health information.

See Pages 30 to 31 of the Revised Project Narrative.

Response: All HIT activities funded by the SIM initiative other than the disease registry and the consent registry are currently in place. The state's investment in enterprise solutions are being leveraged for the SIM activities, and the costs have been allocated in proportion to the additional lives that will be added to the existing services. For example, we estimate that we will add about two million entities into our Enterprise Master Patient Index (EMPI) via the SIM initiative. Hence, associated costs have been attributed to SIM and not the total cost of the EMPI solution.

Effective July 1, 2014 the responsibilities for HIT/HIE were transferred to the Department of Social Services (DSS) via Bill 5597 as was the role of HIT Coordinator. DSS has planned a set of six-meetings beginning on Sept. 17, 2014 with seven Commissioners and other senior government officials to review the existing HIT Strategic and Operational Plan and the recommendations of the technology work group to adopt industry standards for data exchange, and to establish a data Governance structure. The recommendations of the technology work group are centered on the following components:

- promote reusable components through standard interfaces and modularity,
- promote efficient and effective data sharing to meet stakeholders' needs,
- provide a person-centric focus,
- promote interoperability,
- integration and an open architecture, and
- promote secure data exchange.

After the conclusion of these meeting, the state will establish the next steps as well as a sustainability plan for the HIT/HIE going forward.

b) Please describe the value of edge-servers to index clinical and other health databases to support care delivery and analytics. How will you ensure that all agencies/organizations participating in the Model Test will deploy edge-services?

See Pages 29 to 30 of the Revised Project Narrative.

Response: The SIM PMO and its sister agencies will ensure that signing a Data-Use and Reciprocal Support Agreements (DURSA) is a condition for participation in SIM, for example, as a requirement for participation in the Medicaid QISSP, receipt of SIM-funded practice transformation support services, or participation with the consent registry. Consequently, we will have the means to require that every provider participating in SIM allows indexing of data for analysis and aggregation. A DURSA was completed in 2009 by DSS (supported by a CMS transformation grant), which was executed by 3-FQHCs and one hospital. This agreement will be used as a starting point for any future work, as this approach will save the SIM staff time and accelerate our timeframe for making data driven decision making operational.

The use of edge servers allows for data analysis without having to move and secure these large datasets. Additionally, health plans and most stakeholders often worry about security and privacy, this allows them to remain in total control of their data, with complete knowledge that no copies of their data are being analyzed and reviewed. Lastly, this allows for the reports to run against the most updated information in local provider databases and clinical systems.

4. Page 6 of the FOA states, "CMS encourages applicants to propose payment models that directly align with one or more existing Medicare programs, demonstrations, and/or models, such as accountable care organizations (ACOs), primary care medical homes, and bundled payment programs." Please identify the alignment of proposed ACO and PCMH payment models with the Medicare Shared Savings Program and the Comprehensive Primary Care Initiatives, respectively, using Appendices A & B.

See Pages 17 to 19 of the Revised Project Narrative.

Response: Our proposal is grounded in the belief that advanced primary care practice is the foundation for a high-performance, accountable healthcare system. Therefore, the CT SIM proposal is a transformational model with elements than span both the ACO Medicare Shared Savings Program (see Appendix A) and Comprehensive Primary Care Initiatives (see Appendix B).

Medicare Shared Savings Program (SSP)

All Connecticut payers have committed to a payment model that is broadly aligned with the Medicare SSP. Features relating to organizational structure, measure set and shared savings methodology will require further review by the relevant stakeholder groups associated with the SIM and Medicaid to recognize the current stage of development and readiness in Connecticut as well as the need for additional population-specific measures.

Organizational Structure - A substantial majority of Connecticut's primary care providers are employed by or affiliated with one of 15 to 17 Advanced Networks, which we define as independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer. All of these Advanced Networks are organizing to meet, or have already met, the federal definition of a Medicare SSP Accountable Care Organization, as outlined in Appendix A. For these networks, Medicare SSP already represents a de facto standard. By contrast, Federally Qualified Health Centers (FQHCs), which currently serve the primary care needs of over 200,000 Medicaid beneficiaries, are at a more nascent level in determining how best to align their organizational structure with Medicare SSP standards. Connecticut's FQHCs are interested in participation in the Medicare SSP, including the option of participation in a regional ACO, and will explore the mechanism and necessary commitment of public resources that would be needed to expand the SSP from the FQHC Medicaid population to their Medicare patients. Consistent with its commitments to transparency and stakeholder engagement, the Department of Social Services will present the Medicare Shared Savings Program ACO structural standards to the relevant committee of its statutorily established stakeholder group, the Medical Assistance Program Oversight Council, for review and consideration as requirements for the advanced networks that will be selected under the QISSP Request for Proposals.

Measures - Connecticut concurs that substantial alignment among payers around quality measures is essential. The SIM Quality Council has already committed, as a guiding principle, to maximize

alignment with the Medicare ACO measure set. That said, the Council will also use a series of five meetings over the course of fall 2014 to examine the need for additional measure elements of particular interest and concern to Medicaid and other payers. Examples of these include, but are not limited to, measures related to pediatrics, health equity, and behavioral health, drawing from measures endorsed by the National Quality Forum and those that comprise the Medicaid Adult and Child Health Care Quality Measures, the Physician Quality Reporting System, and CMS Meaningful Use Clinical Quality Measures. Consistent with its commitments to transparency and stakeholder engagement, the Department of Social Services will present the Medicare Shared Savings Program ACO measure set, as well as additional measure elements proposed by the SIM Quality Council, to the relevant committee of its statutorily established stakeholder group, the Medical Assistance Program Oversight Council, for review and consideration as component elements of the QISSP Request for Proposals.

Shared savings methodology - Each payer individually negotiates requirements related to minimum attributed lives, minimum savings threshold, and percent of savings shared. As indicated in the Connecticut application, Medicaid will limit its shared savings initiative (QISSP) to upside risk only. We believe that alignment on the above listed parameters is not necessary to achieve the goals of our Model Test, and do not intend to pursue standardization unless this approach creates challenges for provider participants. As a general principle, we are focusing our efforts at alignment on other areas (e.g. measures) deemed essential by our Healthcare Innovation Steering Committee and other advisory bodies. We have completed Appendix A with these assumptions in mind.

With additional time, we would be pleased to provide a matrix illustrating payer specific policies as it pertains to each of the requirements in Appendix A, including Medicaid pending the completion of their planning process later this year.

Comprehensive Primary Care Initiative

Our statewide, multi-payer recognized Advanced Medical Home Standards will be based on the NCQA 2014 standards and NCQA recognition will be a requirement of completing our Glide Path. As such, these new standards, combined with requirements that are the focus of our multi-payer Community and Clinical Integration Program, align with all of the care delivery capabilities that are outlined in Appendix B.

5. Page 6 of the FOA states that the proposed Payment and/or Service Delivery Model must address: "One or more specific payment and/or service delivery models that include, but are not limited to, the state's Medicaid population, state employee population, and/or commercial payers' populations. The payment and/or service delivery models must identify the targeted populations, the number of beneficiaries served, the number of participating providers, and the services to be delivered."

   Considering these requirements, please address the following:

   a) Please identify "all five of CT's major commercial payers" and level of commitment to participate in the payment model.

See Pages 19 to 20 of the Revised Project Narrative.

Response: We define Connecticut's major commercial payers as those with over 5% market share. These payers include the following based on 2013 coverage data:

Commercial Payer	Market Share
Aetna	12.7%
Anthem	48.2%
Cigna	23.8%
Connecticare Insurance Company, Inc	7.6%
UnitedHealthCare Insurance Company	7.6%

In addition, we have been working closely HealthyCT, which in 2014 began offering individual coverage on our health insurance exchange, and Harvard Pilgrim, which is also preparing to enter the Connecticut market.

All of Connecticut's payers have strongly endorsed a transition from volume to value-based payment as evidenced in the following excerpts from their letters of support. All payers have, as of the submission of this response, specifically endorsed broad alignment with the Medicare SSP.

CT Association of Health Plans

The Connecticut Association of Health Plans (CTAHP) and its member companies, Aetna, Anthem, Cigna, ConnectiCare, United, and Harvard Pilgrim, are pleased to submit this letter in support of Connecticut's State Innovation Model (SIM) Test Grant Application that is being submitted by the Office of the Healthcare Advocate to the Center for Medicare and Medicaid Innovation (CMMI).

CTAHP represents all of the major health insurance carriers in the state as well as the 2 million plus members that they serve. Connecticut's carriers range from national large companies, to those whose primary focus is Connecticut specific and the Association is inclusive of both for-profit and not-for-profit organizations.

… As has been demonstrated throughout the implementation of the ACA, the commercial industry has not only embraced a value centered philosophy, but has acted upon it. Connecticut's carriers have made substantial investments in the accountable care organization (ACO) and medical home models envisioned under SIM and the carriers are experienced leaders in supporting provider practices that have demonstrated their commitment to transforming into high value and efficient primary care settings that employ care teams and practice population management. As such, the industry is very supportive of any SIM elements that build upon these efforts without compromising any of the reforms already underway by the carriers.

Aetna

Aetna is also a leader in advancing integrated value-based products as successors to outmoded fee-for-service models – including value-based insurance design (VBID), patient-centered medical homes (PCMHs), and accountable care organizations (ACOs).

Therefore, we share Connecticut's SIM vision to:

- *Establish primary care as the foundation of a care delivery system that is patient and family centered, coordinated, and evidence driven, and which rewards value over volume.*

… We look forward to a continued active participation in the development of various committees' work plans, including:

… The development of a shared savings program (SSP) arrangements similar to those employed in the Medicare SSP and which gives carriers and providers the flexibility to determine the specific terms.

Anthem

Our Enhanced Personal Health Care program allows us to maximize collaboration with our provider network. Some important elements of this program include: actionable data transfer, so physicians can better manage the health care of their patients; care management tools; and transformation resources. A central facet of this program is payment redesign, moving from payment based on volume to payment based on value. Practices are reimbursed for care coordination activities and also have an opportunity to earn shared savings upon reaching quality targets.

… We recognize the importance of value-based payment methods and we will participate in both the Equity and Access Council and Practice Transformation Council in order to align efforts and create standards for a successful multi-payer Advanced Medical Home model.

Cigna

… As has been demonstrated throughout the implementation of the ACA, Cigna has not only embraced a value-centered philosophy, but has acted upon it. We have made substantial investments in our Collaborative Accountable Care models, which combine elements of the accountable care organization (ACO) and medical home models envisioned under SIM and the carriers are experienced leaders in supporting provider practices that have demonstrated their commitment to transforming into high value and efficient primary care settings that employ care teams and practice population management. Cigna has several ACO relationships throughout Connecticut, including the Greenwich Physicians Association, Integrated Care Partners/Hartford Healthcare, New Haven Community Medical Group, ProHealth Physicians, Inc., Saint Francis HealthCare Partners and others. As such, we are very supportive of any SIM elements that build upon these efforts without compromising any of the programs or standards we have already implemented.

… Cigna also recognizes the importance of value-based payment methods that hold primary care providers accountable for quality, care experience and total cost of care. We support applying our best efforts to financially align with other payers in the adoption of shared savings program (SSP) arrangements similar to those employed in the Medicare SSP.

ConnectiCare

… By means of this letter, ConnectiCare is declaring its support for the Connecticut State Innovation Model Test. Specifically, ConnectiCare is committed to:

- *Work with the SIM Steering Committee and other stakeholders in the State towards a goal of achieving better alignment of payment and contracting strategies that reward value over volume; …*

- *Offer alternative risk-based reimbursement models that may include shared savings program (SSP) arrangements similar to those employed in the Medicare SSP, pay for performance, and global or capitated payments designed to meet the needs of our customers and provider partners;…*

Harvard Pilgrim

… At its core, the SIM initiative seeks to transition from a volume-based health care delivery system to value-centered approach focused on the individual. By doing so, important advancements are proposed, including: new value-based payment methodologies; enhanced collaboration with providers in the community through practice transformation initiatives; and consumer empowerment through increased transparency.

Harvard Pilgrim recognizes the importance of value-based payment designs as a tool to improve the quality of care for members. We support the importance placed on these payment designs in the SIM test grant, and as a company hold significant experience with alternative payment methodologies. As you are undoubtedly aware, Massachusetts has undertaken its own initiative in payment reform. Harvard Pilgrim embraced the goals outlined in this effort, and the company currently employs a number of risk-based (both upside and downside risk) contracts with providers throughout New England. We have found that these arraignments provide enormous value to our members because their care now focuses on health outcomes and places primary care providers at the center of a larger care management team.

HealthyCT

… HealthyCT shares the vision outlined in the application to establish primary care as the foundation of a care delivery system that is consumer and family centered and which rewards value over volume.

… Finally, our A-PMPM program aligns nicely with the SIM grant proposal in supporting the transition to value-based payment methods which should help drive a much needed change in focus from volume to value.

UnitedHealth Group

… That is why we are pleased to provide this letter of support for the general concepts and principals outlined in the State of Connecticut's State Innovation Model Plan – Model Test Grant application that is part of the State's Center for Medicare and Medicaid Innovation (CMMI) – State Innovation Model Grant.

… UnitedHealth Group continues to work collaboratively with many varied stakeholders across the country to test and sustain new payment and service delivery models … These important collaborations include…value-based payment reform programs. Our deliberate evaluation of these programs proves that they are successful and have meaningful outcomes for quality and cost.

… UnitedHealth Group hopes to continue to work with the State to assist in implementing Connecticut's State Innovation Plan and its Model Test Grant application. Our experience is extensive in working with primary care practices and other providers across the country…to create successful value-based and incentive based provider payment programs to increase the quality of care for our members and reduce costs, and we have sophisticated and well used member transparency tools for both cost and provider performance information.

b) Describe the percentage of non-Medicare revenue in your state that will be in your payment model.

Response: Table 1 below provides a summary of the percentage of non-Medicare revenue (commercial + Medicaid) that is projected to be included in our payment model for a five year period, the first three years of which include the SIM period of performance.

Table 1

Percent Revenue in our Payment Model	2016	2017	2018	2019	2020	2021
Commercial (including ASO)	40%	55%	65%	75%	85%	90%
Medicaid (excluding duals)	30%	30%	60%	60%	85%	90%
Total Non-Medicare	38%	50%	64%	72%	85%	90%

c) Indicate the number of providers participating in your model.

Response: See Appendix C, Tables 4, 5 and 7.

6. Page 9 of the FOA states the applicant must "describe anticipated cost savings resulting from specified interventions, including the types of costs that will be affected by the model and the anticipated level of improvement by target population and basis for expected savings (previous studies, experience, etc.)" and "describe expected total federal cost savings and return on investment during the project period for the overall state model."

   Considering these requirements, please address the following:

   a) Describe the amount of Medicare and Medicaid savings expected to be produced under your proposal.

See bottom of page 3 of the Financial Analysis.

Response: The table at the bottom of page 3 of our financial analysis provides the gross and federal share of the projected savings by the end of the period of performance and after a 10 year period. Specifically, if fully and successfully implemented, we predict that our Model Test will achieve $3.6 billion in federal savings in CY 2024, net of program investments and value-based payments to providers as summarized in Table 2 below.

Table 2

ROI NPV at 2015 dollars	4-Year Project Period		10-Year Period	
	Net Savings	ROI	Net Savings	ROI
Medicare	$ 226.5	242.2	$ 2,916	1,337.8
Medicaid/CHIP	$ 38.0	8.6	$ 1,214	62.2
Subtotal	$ 264.5	250.7	$ 4,129.9	1,400.0
Federal Share	$ 190.3	4.0	$ 3,604.1	49.7

b) Please describe the quality targets that you expect to achieve for the both the Medicare and non-Medicare populations.

See Pages 45 to 48 of the Revised Project Narrative.

Response: Changes in the delivery system over the Model Test period are expected to allow the State to achieve the access and quality targets identified in Table 6 on page 47 of our Project Narrative and reproduced in Table 3 below. These quality targets for both the Medicare and non-Medicare populations are based on measures derived from three sources: Connecticut BRFSS data, HEDIS measures, and claims data from the CT Hospital Inpatient Discharge Database (HIDD) and APCD. Hospitalizations for ambulatory sensitive conditions using the AHRQ Prevention Quality Indicators will serve as a critical measure of quality. Baselines using 2012 data from the HIDD are presented in Appendix D separately among the Medicare, Medicaid, and privately insured populations, along with quality targets for each population over the course of the proposed grant. Projections in this table draw on the 2012 base rates for hospitalizations and assume a stable denominator over the duration of the Test Grant. Base rates will be recalculated with the most current data available at the beginning of the grant, and population totals will be monitored over the course of the grant and adjusted accordingly.

Available HEDIS measures for all CT health plans will be compiled after annual submission annually and used to measure performance in care delivery and to track changes associated with payment reform and practice transformation initiatives. When plans submit their HEDIS data to NCQA, they include the eligible population, the oversampling rate, the number of numerator events in the final sample, and various exclusions, as well as the rate (e.g. percent receiving LDL-C screening). In addition to examining plan specific changes, We will use these data to weight the performance indicators from each plan to develop a statewide estimate for individuals in Medicare, a commercial health plan, or Medicaid. Managed care organizations in Connecticut are required by law to report HEDIS data, so coverage is excellent. We will use BRFSS data to estimate the proportion not in a health plan and estimate the bias for measures also assessed in the BRFSS."

Population denominators will be also be collected from payers at selected intervals.

Quality measures and targets related to hospitalizations will be calculated using the AHRQ Prevention Quality Indicators (PQIs), 14 measures of conditions managed in ambulatory settings. Additional statewide measures and targets will be established for behavioral health, oral health, and health equity pending the recommendations of the Quality Council.

Table 3

Category/Measure	Base	2016	2017	2018	2019	2020
% of adults w/ regular source of care	83.9	85.7	87.5	89.4	91.2	93.0
Risk - std. all condition readmissions	15.9	15.3	14.8	14.2	13.7	13.1
Amb Care Sensitive Cond Admissions	1448.7	1398.0	1347.3	1296.5	1245.8	1195.1
Children well-child visits for at-risk pop	62.8	64.1	65.3	66.6	67.8	69.1
Mammogram for women >50 last 2 years	83.9	84.7	85.4	86.2	87.0	87.7
Colorectal screening - adults aged 50+	75.7	77.2	78.8	80.3	81.9	83.6
Colorectal screening - Low income	64.9	65.6	66.2	66.9	67.5	68.2
Optimal diabetes care - 2+ annual Alc tests	72.9	74.3	75.7	77.1	78.6	80.1
ED use - asthma as primary dx (per 10k)	73.0	71.2	69.4	67.6	65.8	64.0
ED use - asthma as primary dx (Hispanics)	170.5	168.0	165.5	163.0	160.5	158.0
% of adults with HTN taking HTN meds	60.1	62.0	63.9	65.7	67.6	69.5
Premature death-CVD adults (per 100k)	889.0	819.2	749.4	679.6	609.8	540.0
Premature death-CVD black adults (/100k)	1737.6	1562.1	1386.6	1211.0	1035.5	860.0

Connecticut Medicaid collects and reports a full array of quality measures across its clinical programs. With some notable exceptions, these measure sets are complete since the beginning of calendar year 2012, when the Department transitioned entirely to an administrative services model of

care. These include an annual Consumer Assessment of Healthcare Providers and Systems surveys of both adult and child members, a complete panel of HEDIS and CHIPRA measures, as well as several measures of special interest to the Department and its stakeholders. Examples of these 'home grown' measures are the incidence of sexually transmitted infections in males (not just in females, which is the HEDIS measure) and a more detailed measure of 30 day hospital readmissions which includes all ages and diagnoses. Connecticut Medicaid is participating in the Quality Council and intends to adjust its quality measures pending the recommendations of the SIM Quality Council and in consultation with the Medical Assistance Program Oversight Council's Care Management Committee.

c) Please indicate a baseline for chosen population health measures.

See Pages 41 to 42 of the Revised Project Narrative.

Response: As stated in the application, the plan for improving population health will utilize and build upon the DPH's recent State Health Assessment, State Health Improvement Plan (Healthy Connecticut 2020) and the state Chronic Disease Prevention Plan. This revised plan will be completed during Years 1 and 2 of the Test Grant. As a result the initial application did not articulate a comprehensive set of population health measures and targets. However, three of the measures presented in Table 3 of the Project Narrative should be considered examples of population health measures that we will monitor over the course of the project: Percent of adults with a regular source of care; frequency of well-child visits, especially for at-risk populations; and premature death due to cardiovascular disease among adults. The measures listed on page 47 are all derived from population-level datasets (e.g. BRFSS, Hospital and ED discharge data, Vital Statistics). Baselines are provided in presented in Table 6 of the Revised Project Narrative (page 47).

In addition, the State Chronic Disease Plan has established population measures with baselines and targets for obesity, tobacco and diabetes, which are delineated in Table 4 below. These measures will serve as a baseline for anticipated interventions targeting these three conditions.

Table 4

Category/Measure	Base	2016	2017	2018	2019	2020
Percent of adults who are obese	24.50%	23.65%	23.48%	23.30%	23.13%	22.95%
Percent of children who are obese	18.80%	18.15%	18.03%	17.90%	17.78%	17.65%
Percent of children in low-income households who are obese	38.00%	36.65%	36.40%	36.10%	35.83%	35.55%
Percent of adults who currently smoke	17.10%	15.60%	15.30%	15.00%	14.70%	14.40%
Percent low income adults who smoke	25.00%	23.58%	23.30%	23.00%	22.70%	22.43%
Percent of youth (high school) who currently smoke	14.00%	13.28%	13.14%	13.00%	12.85%	12.72%
Percent of adults with diabetes	8.50%	8.14%	8.07%	8.00%	7.93%	7.86%

Percent of adults with diabetes – low income	14.30%	12.65%	12.31%	12.00%	11.65%	11.32%

Additional population health priorities, measures and targets (e.g. child wellness, vaccines and infant mortality), will be identified by the Population Health Council during the development of the population health plan in Year 2 of the Test Grant. Baselines for population health measures will include overall population totals and stratified totals by age, race and ethnicity, and payer (Medicare, Medicaid, commercially insured), all of which are available in the source data (e.g., HEDIS, BRFSS, Vital Statistics Registry).

7. Page 32 of the FOA states, "The applicant must also establish accountability targets for the project, including specific quarterly milestones and metrics associated with each investment or activity that would be financed in whole or in part by this award. Projected quarterly targets for the test period should indicate the number and/or proportion of health care providers, hospitals, and beneficiaries that will be engaged by each Model Test component." Identify quarterly accountability targets and thresholds the state will use to measure the success of the innovation project. Specifically, identify discrete metrics (include numerator/denominator, where possible) and corresponding timelines that will gauge the success of the state's initiatives and allow for CMS to monitor the award throughout the SIM performance period.

See Pages 43 to 45 of the Revised Project Narrative

Response: Major operational plan milestones include Medicaid Quality Improvement and Shared Savings Program (Medicaid QISSP) implementation, involvement in the Community and Clinical Integration program, percent of primary care providers and beneficiaries in shared savings programs (SSPs) and percent of employers adopting value based insurance designs (Table 1; Test Model submission and Tables 1-7 in Appendix C of this response).

As part of the Test Model evaluation process we will monitor the measures described in Appendix C, Tables 1 through 7. In addition, the differential adoption by practice groups of new benefit and payment models will allow rigorous assessments of, for example, the impact of employee benefit plans (e.g. VBID) and provider reimbursement (e.g. SSP) on care patterns, costs, and health outcomes. Assessment of the impact of different delivery, benefit, and payment models will require information on rates of adoption.

In anticipation of potential Model Test implementation, the evaluation team is conducting a state wide survey of 1,200 primary care and specialist physicians in Connecticut to assess the readiness of the physician workforce in the state to assume financial risk and provide services consistent with the advanced medical home model. Drs. Cleary and Aseltine have conducted numerous surveys of physicians and it is clear that many physicians are unaware of, or cannot report accurately about, the financial models under which they are reimbursed. The general problem of lack of awareness of financial arrangements is exacerbated by the fact that most physicians receive reimbursement from multiple health insurance plans, both public and private. Beneficiaries have difficulty reporting the type of insurance coverage they have, and have very little, if any, understanding of how their physician is reimbursed.

Thus to collect data that will allow us to assess the pace and impact of test model changes, we will use three general strategies. Each quarter we will elicit information on rates of participation available

from the 5 major CT insurers, Medicare, and Medicaid (e.g., percent of primary care providers in shared savings arrangements). For some aspects of program pace (e.g., implementation of the Community and Clinical Integration Program), we will conduct quarterly surveys of the CT Advanced Networks (currently 17) and FQHCs. For those aspects of the program in which we elicit information about participation form the Advanced Networks, we also conduct a survey of a sample of 1,000 health care providers not in Advanced Networks. That information will allow us to determine the extent to which providers in the Advanced Networks are making changes that are greater than other providers in CT.

Survey strategy

When we have conducted national surveys of health care plans, we typically have surveyed both the Chief Medical Officer and the Lead Administrator. The major insurers have agreed to designate a contact person for providing information for the quarterly reports. To collect information from the Advanced Networks and in the annual survey of providers, we will identify a clinical and administrative head to provide the information required. The surveys of Advanced Network representatives and non-affiliated providers will be conducted by mail with a telephone follow-up to non-responders. Survey development will include pilot testing to insure questions are clear and consistently understood. Data collection will be conducted by professional survey firms that will bid on specific projects and activities. The current CT physician survey is being conducted by the Center for Survey Research (CSR) at the University of Massachusetts-Boston. An example of another firm that we would solicit bids form is the Survey Research Center at the University of Michigan. Both are University based survey research organizations with the staff and resources to carry out all phases of multi-mode survey research and have significant experience conducting dual-language surveys, Spanish/English in particular. Drs. Aseltine and Cleary have extensive experience in working with both organizations on numerous large-scale projects.

References:

Complexity of arrangements): Landon BE, Wilson IB, Cleary PD. A Conceptual Model of the Effects of Health Care Organizations on the Quality of Medical Care. JAMA; 1998; 279(17):1377-1382.

Experiencing surveying physicians and plans:

McInnes K, Landon BE, Malitz FE, Wilson IB, Marsden PV, Fleishman JA, Gustafson DH, Cleary PD. Differences in patient and clinic characteristics at CARE Act funded versus non-Care Act Funded HIV clinics. AIDS Care. 2004; 16(7): 851-857.

Landon BE, Wilson IB, McInnes K, Landrum MB, Hirschhorn L, Marsden PV, Gustafson D, Cleary PD. Effects of a quality improvement collaborative on the outcome of care of patients with HIV Infection: the EQHIV study. Ann Int Med, 2004; 140(11): 887-896.

Landon BE, Aseltine R Jr, Shaul JA, Miller Y, Auerbach BA, Cleary PD. Evolving dissatisfaction among primary care physicians. Am J Mang Care; 2002; 8(10): 890-901.

8. Page 55 of FOA states, “States are expected to cooperate in the evaluation process and provide the necessary data to evaluate state models. This data will be shared with the state evaluator team and with Innovation Center evaluation contractors.” Continued on page 56, “The State evaluation contractor will

be expected to create State evaluations relevant to all populations and payers involved in the State initiative." Considering these requirements, please address the following:

a) What is the state's ability to provide current identifiable, individual Medicaid claims data to the federal evaluator/CMS for beneficiaries affected by SIM?

See Page 50 of the Revised Project Narrative.

Response: Connecticut Medicaid has extremely strong analytic capacity and expertise. Since 2012, Connecticut Medicaid has had the benefit of a fully integrated set of claims data across all categories of Medicaid services. The Department's medical ASO, CHN, maintains this data within the Utilization & Cost Analyzer (UCA) system, an analytical and data discovery tool that includes Medicaid claims, member eligibility, and provider data. UCA utilizes QlikView software and is uploaded monthly with claims, member eligibility, and provider data directly from CHN's data warehouse specific to the Connecticut Medicaid program. The data warehouse is populated with data that is received from the Department and its claims processing partner, HP. UCA provides a simple, rapid, and comprehensive means of assessing medical cost and utilization trends in various cuts of the claims, member eligibility and provider data with multiple layers of drillable investigative analysis, down to the claim, member and provider level.

b) What is the state's ability to provide individual-level commercial claims data to the federal evaluator/CMS for beneficiaries/providers affected by SIM? Include a description of current data infrastructure that would support this data request, such as an all-payer claims database.

See Pages 50 to 53 of the Revised Project Narrative.

Response: The All-Payer Claims Database (APCD) that Access Health CT (AHCT) is developing will have commercial data with member identifiers. All of Connecticut's health plans have indicated their support for the APCD as evidenced in each of their letters of support for SIM. Moreover, they have all recently reaffirmed their commitment to use the APCD as the primary and preferred source for the production of commercial health plan data and reports to meet the needs of the state and federal evaluation of the SIM program.

The SIM PMO will convene a SIM Program Monitoring team comprised of APCD officials, participating health plans, and state and federal evaluators in order to further specify the requirements of the federal and state evaluations and to determine whether all required elements for the evaluation are addressed in the approved Data Submission Guidelines and, if not addressed, appropriate steps will be taken to modify these guidelines including necessary approvals. The SIM Program Monitoring Team will further determine the level of data identification necessary to achieve the purposes of the state and federal evaluations.

The APCD data infrastructure will be managed by an outside data and analytics vendor with capabilities of maintaining and operating a robust data ETL process, transformation of this data from various data submitters into an equivalent data base structure and maintain historical data of eligibility, medical and pharmacy claims, and provider information.

There will be two environments in this data infrastructure.

i. Production environment – will be used to generate healthcare costs and utilization reports on the web, to be primarily used and accessed by the data analytic vendor, and

ii. Managed Hosting environment – with an enclave style access management primarily for internal and external users, e.g., SIM analysts, CMS and the federal evaluator.

The Managed Hosting server will be accessible via secured VPN connectivity. Users will have access to permissible directories via a Data Enclave environment. The environment will be firewalled from outside intrusion, and is only accessible to authorized users. Researchers and analysts involved with SIM will have access to analytic tools in secure environment to work with the data, including such applications as SQL, SAS, and other applications. Data can be accessed to generate member and provider list for relevant ACOs and FQHCs; reports can be run for risk-adjusted costs and utilization reports by various participating entities; evaluate pre- and post-intervention effects due to SIM initiative; develop ID and Stratification based on clinical groupers for members in the ACO or FQHC groups; and, various other reports on claims-based compliance and other quality indicators.

The vendor for data intake and integration is targeted to be in place at the beginning of 4th quarter 2014. The timeline for data intake and integration are as follows:

Table 5. Data In-Take Plan for APCD

Activities	Target Date
1. Develop data intake infrastructure for commercial and public (Medicare) payers	12/15/2014
2. Test for stability and efficiency of data ETL process	1/15/2015
3. Receive and upload test data	1/31/2015
4. Data Quality validation	
Ensure files received from data submitters are accurate	2/15/2015
Ensure data contents from various files are accurate	2/28/2015
Ensure files are transmitted are complete – control total	3/15/2015
Ensure data files conform to general benchmarks	3/15/2015
5. Data warehouse completed and tested	4/15/2015
6. Historical data in-take	6/15/2015
7. Analytic environment tested	7/1/2015
8. Production Environment tested	7/15/2015
9. Production Environment deployed	8/1/2015

c) What is the state's ability to provide Medicare identifiers to the federal evaluator/CMS for beneficiaries affected by SIM?

See Page 53 of the Revised Project Narrative.

Response: The plan for Connecticut's APCD includes the collection of Medicare fee-for-service data from CMS. The data set will have Medicare beneficiaries' information with claims level details. If

allowed by CMS, that data can be used to support SIM initiative. We intend to collect monthly files from CMS. If not available then we can at least collect information at quarterly time intervals. Part D of Medicare will also be available. As part of the collection effort, the APCD intends to collect Part C Medicare data as well from health insurance carriers. Data collected from Medicare program will be maintained in the same data infrastructure as discussed in 8(b) above. As such, the APCD will be a source of linked and de-duplicated individual claims level data, inclusive of Medicare.

Connecticut will compile and share information about the identity of the Advanced Networks and FQHCs that are participating in the MQISSP in each of the two waves and receiving AMH Glide Path and CCIP support. We believe that CSM would be the most reliable source of information about Medicare beneficiaries attributed to and benefiting from their participation with these providers. We would request that CMS share information about Medicare attributed beneficiaries with the state evaluators to support our rapid cycle learning and evaluation.

d) Are there any laws and/or regulations preventing the disclosure of necessary records or data to the federal contractor performing the evaluation of SIM?

See Pages 53 to 56 of the Revised Project Narrative.

Response:

Medicaid: Federal Medicaid law provides that state Medicaid agencies must restrict the use and disclosure of information concerning Medicaid applicants and recipients "to purposes directly connected with administration of the plan." 42 U.S.C. § 1396a(a)(7); 42 C.F.R. § 431.300(a). More specifically, the federal regulation defines "purposes directly related to plan administration" as including "(a) establishing eligibility; (b) determining the amount of medical assistance; (c) providing services for beneficiaries; and (d) conducting or assisting an investigation, prosecution or civil of criminal proceeding related to administration of the plan." 42 C.F.R. § 431.302.

State law, specifically section 17b-90(b) of the Connecticut General Statutes, similarly provides that, except for purposes directly connected with the administration of the Department of Social Services programs, disclosure of information about persons applying for or receiving assistance from the Department, or persons participating in the Department's programs, is prohibited. State regulations provide that "purposes directly connected with" the Department's programs includes "an audit or similar activity conducted in connection with the administration of the program by any governmental entity authorized by law to conduct such audit or activity." Section 1020.10 of the Uniform Policy Manual.

The Connecticut Department of Social Services will regard disclosure of necessary records or data to the federal contractor performing evaluation of SIM to be for purposes directly connected with administration of the plan. Assuming the federal contractor has a business associate agreement with CMS, the Department will enter into data use agreements (DUA) with CMS or the federal contractor for purposes of data sharing. These DUAs will parallel those into which the Department has entered with CMS in support of data sharing for the Demonstration to Integrate Care for Medicare-Medicaid Enrollees.

APCD: APCD enabling legislation permits the sharing of de-identified, individual level data for commercial payers. Medicare data sharing will be governed by CMS rules particularly supporting

CMMI funded demonstration projects. However, it does not permit the sharing of data on identifiable members to external entities such as state or federal agencies and their respective evaluators. The SIM PMO will convene a team comprised of APCD officials, participating health plans, and state and federal evaluators in order to further specify the requirements of the federal and state evaluations and to determine whether the purposes of the evaluation can be achieved with an individual level, de-identified data set or whether a limited data set with date of service and zip code will be required. If the latter is necessary to achieve the purpose of the evaluation, the state will propose legislation that will enable the APCD to share the limited data set for the purpose of the SIM evaluation. We anticipate that such legislation can be achieved by June of 2015. If a more complete set of identifiers is required, additional research will be necessary to determine whether an amendment to the APCD legislation would be sufficient for this purpose.

General/HIPAA: SIM will be in compliance with the new HIPAA/HITECH rules effective September 22, 2014. We recognize that covered entities must bring all of their Business Associate Agreements ("BAAs") into compliance with the Rules and that the new Rules also apply this requirement to Business Associates' agreements with their covered subcontractors. While the Rules in some respects represent a major departure from the existing HIPAA and HITECH requirements, many of the new provisions accept without change the requirements that the HHS had previously proposed in the interim final HITECH Breach Notification Rule, in October 2009, and in the proposed Privacy, Security and Enforcement Rules updates in July 2010 (the "Interim Rules"). Entities that have aligned their practices with the Interim Rule will, therefore, have fewer changes to implement.

e) Is the state prepared to fully cooperate with the contractor performing the federal evaluation? This includes, but is not limited to the following:

See Page 56 of the Revised Project Narrative.

i. Sharing identifiable data from any available payer (public or private) concerning beneficiaries and providers affected by SIM to coordinate primary and/or secondary data collection activities to reduce participant burden; and

Response: The state will fully cooperate with the contractor performance the federal evaluation as described in our responses to 8(a-d) above.

ii. Allowing CMS to review and comment on methods and results from the state evaluation before publication of results.

Response: The state will provide informant in a timely manner that will allow CMS to review and comment on methods and results from the state evaluation before publication of results.

f) How will the state's proposed evaluation agent coordinate with any program monitoring efforts as well as the federal contractor performing the evaluation?

See Page 56 of the Revised Project Narrative

Response: The SIM Evaluation Team is committed to meeting with CMS and its external evaluator and the SIM Rapid Response Team (see Project Narrative, Section VI) as frequently as is necessary to inform and monitor program implementation and to allow for external oversight and evaluation. Drs. Aseltine and Cleary and their project management teams will coordinate the quarterly reporting relevant to SIM program pace and performance monitoring and periodic outcome assessments and be responsible for meeting with the Steering Committee and federal evaluation contractor every other week for the first 6 months of the project, and monthly thereafter. Dr. Cleary and his team will coordinate and lead the meetings with the SIM Rapid Response Team on pace and performance monitoring, and Dr. Aseltine and his team will coordinate and lead the meetings with CMMI and/or the federal evaluation contractor. Meetings with CMS and the federal evaluation contractor will also provide opportunities for CMS to review and comment on methods and results from the state evaluation prior to publication and dissemination of findings.

9. Describe how the proposed Payment and/or Service Delivery Model will be integrated with the Plan for Improving Population Health. Additionally, describe proposed collaboration across state agencies in addressing social determinants of health. .

See Pages 69 to 73 of the Revised Project Narrative.

Response: The proposed collaboration under SIM among state agencies builds on a solid foundation of joint initiatives in related areas. Several departments of the state are meaningfully involved in collaboration in support of addressing social determinants of health (SDH), illustrative examples include:

- The Department of Public Health (DPH) is collaborating with the Department of Social Services (DSS) and other stakeholders on the national Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality, whose goal is to reduce infant mortality and improve birth outcomes. DSS already has diverse strategies in place, including medical ASO Intensive Care Management support for women with high risk pregnancies, PCMH support, an obstetrics pay-for-performance project designed to increase the incidence of full-term vaginal births, and the dental ASO effort funded by HRSA under which pregnant women are being engaged for purposes of preventative oral health - including such strategies as primary care providers issuing "prescriptions" for dental visits. In collaboration with DPH, these strategies and others will be coordinated across payers with the intent of improving outcomes.

- Additionally, the Department of Children and Families (DCF) is partnering with DSS, DPH, legislators, judges and other stakeholders on the Three Branch project. Three Branch is a multi-state initiative convened by the National Governors Association Center for Best Practices, the National Conference of State Legislatures, Casey Family Programs, the National Center for State Courts, and the National Council of Juvenile and Family Court Judges. The aim of the Three Branch Institute is for participating states to improve social and emotional well-being for children in foster care.

- Finally, DSS, DCF and the Department of Mental Health & Addiction Services are collaborating with the Clifford Beers Child Guidance Clinic in support of its CMMI Innovations Grant,

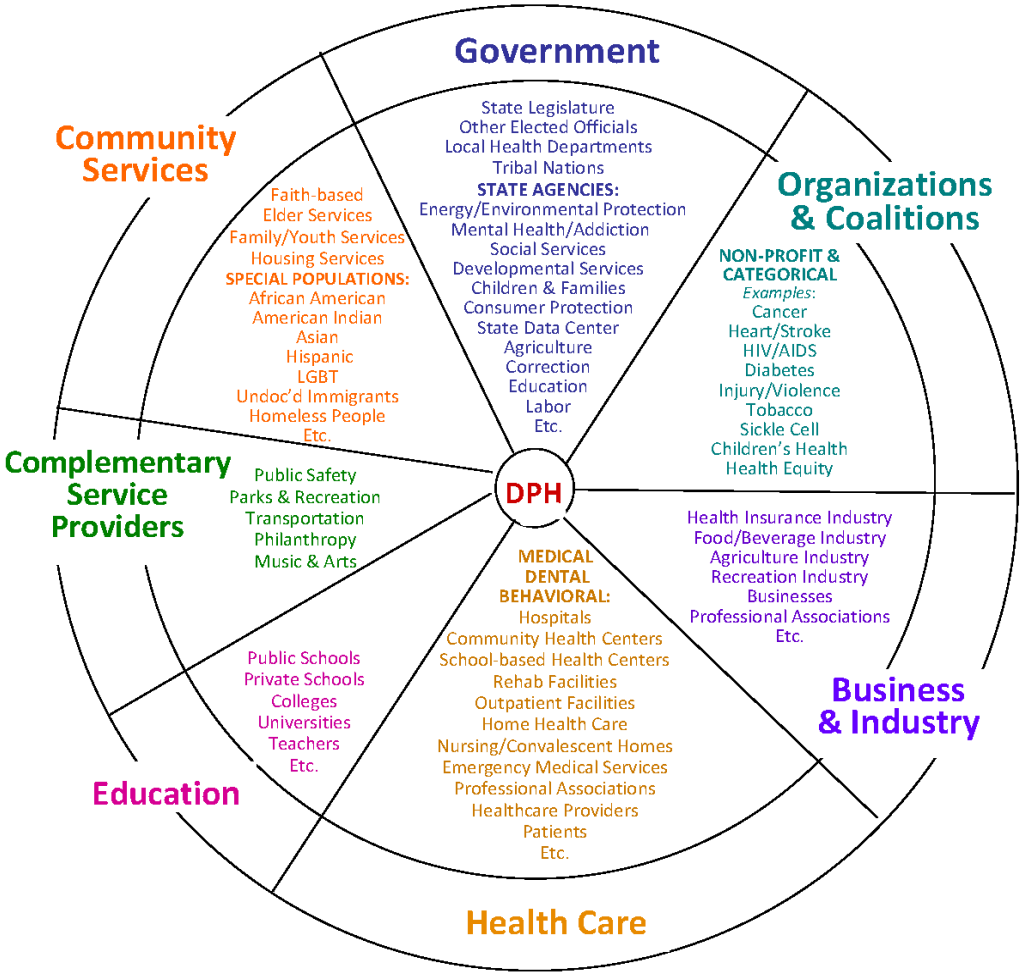
WrapAround New Haven- Family Centered Model of Care. The wraparound process is an intensive, individualized care management process for youths with serious or complex needs. Teams of individuals who are relevant to the well-being of the child or youth (e.g., family members, other natural supports, service providers, and agency representatives) collaboratively develop an individualized plan of care, implement this plan, and evaluate success over time. The wraparound plan typically includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends, kin, and other people drawn from the family's social networks.

In the context of SIM, we aspire to build on these ongoing collaborative initiatives and aim to ensure that the Plan for Improving Population Health and the proposed Payment and Service Delivery Model will be mutually informative and re-enforcing particularly with respect to addressing social determinants of health and health equity. The following specific activities and mechanisms to achieve integration are planned:

- As described on page 2 of our application, the Population Health Council is responsible for developing the Population Health Plan. It will be developed from the members of the Advisory Council and Health Systems Work Group of the DPH-led State Health Improvement Planning Coalition. This Coalition is comprised of representatives from key sectors and health stakeholders including hospitals and community health centers, Departments of Education Transportation, and Environmental Protection, various community coalitions, and philanthropies. We will use the Sector and Stakeholder Wheel to ensure broad representation and identify key agencies and offices with potential influence over SDH to be included on the Population Health Council. Illustrative examples include the Office of Early Childhood, Department of Housing, Insurance, Social Services and other payers.

  Within the Population Health Council, a five to six member executive committee will be formed to inform and guide the work of the Council. Participants of the executive committee will collaborate closely and share decision making authority. Led by DPH, the committee will include, for example, representatives from DSS, the PMO, and key entities and organizations with specialized knowledge and expertise in SDH

Sector and Stakeholder Wheel for Population Health Planning



- The Population Health Council will review potential health equity and SDH priorities and measures and make a recommendation to the Quality Council for inclusion of such measures in the common quality scorecard by year 3. The DPH chronic disease director, Mehul Dalal, MD, is one of the chairs of the Quality Council. By serving in this role, DPH will have a thorough grounding in the parameters for scorecard development and the relationships with payers necessary to support the gradual introduction of SDH considerations in measure selection in general, and as it pertains to our goal to reduce health equity gaps.

- The Population Health Council, as part of its review of evidence-based interventions and root cause analyses work to identify priority areas for action to advance health equity (page 2) will make specific strategy recommendations to the Practice Transformation Task Force and Health Equity and Access Council to inform their work in advising service delivery and payment reform

implementation. The Population Health Council will also be invited to review and comment on the CCIP plan prior to implementation (by July 2015), especially as it relates to technical assistance in priority areas on which SDH has direct bearing including *community integration* and *reducing health equity gaps*.

- To ensure that Population Health planning is current with on-the ground experience with practice transformation and payment reform, the Medicaid QISSP, CCIP, and VBID leads will be requested to submit and/or present formal progress updates to the Population Health Council quarterly. CCIP and in particular, will be well positioned to assess, from the primary care practice perspective, gaps and needs in community-based preventive services that could inform the design of PSCs and ultimately HECs.

- The DPH-based Population Health Planning leads will participate in SIM Core Team meetings to ensure that the practice transformation and payment reform initiatives are current with developments and recommendations of the Population Health Council. In addition DSS will consult on a regular basis with DPH Population Health Planning leads regarding Medicaid QISSP design, implementation and monitoring.

- Medicaid QISSP participating FQHCs and Advanced Networks will be required to integrate use of community health workers and other specific strategies designed to address social determinants of health (e.g. assessment processes that gauge food security, physical safety and housing stability as a threshold to beneficiary readiness to engage on matters related to physical and behavioral health).

- Finally, DPH, DSS, and the PMO will execute a Memorandum of Understanding that details their joint planning and administrative responsibilities by January 2015.

10. Identify the recruitment process – including hiring entity – and training along with timeframes for staff the state will hire to implement the proposal.

    See Pages 67 to 69 of the Revised Project Narrative.

    Response:

    PMO: Assuming notice of award by October 31, 2014, we anticipate that PMO positions will be formally established by January 2015 and hired between March and April, 2015. The PMO/Director of Healthcare Innovation will offer three sessions of a "New Staff Orientation to SIM and State Agencies" to educate new hires about the SIM initiative and activities related to health system transformation. We intend to offer these sessions to PMO, DSS, DPH and UCHC hires in March, May and July, 2015. In addition, we will integrate DSS- and DPH-led orientation sessions so that all SIM involved staff have an understanding of the scope, history and inter-dependence of these agencies and their programs and activities.

    DSS: The Department of Social Services will utilize its existing civil service recruitment and hiring process. From the point of articulating need for a position through the process of gaining approvals from the Department of Administrative Services and the Office of Policy & Management to interview and hiring process typically takes six months of lead time. Assuming notice of award by

October 31, 2014, we anticipate that DSS positions will be formally established by January 2015 and hired between March and April, 2015. Agency and program specific orientations, and mentoring of job duties will be provided by hiring supervisors.

DPH: follows state operations and processes for hiring set by the Office of Policy and Management and the Department of Administrative Services. The processes for recruitment, interviews, and selection are consistent with negotiated union contracts, and Affirmative Action and Equal Opportunity laws. Timeframes for receiving approvals to hire, posting position vacancies, candidate interview and selection process, and administration for formal hiring takes approximately 3 months under normal circumstances and up to 6 months or more particularly if recruitment requires an examination process to update and populate a list of eligible candidates that can apply for the open positions.

Each agency will be asked to prioritize hiring of positions according to critical need and based on the operational plan and timeline. It is anticipated that hiring will occur in three waves. For the Population Health component of the SIM Test application, DPH will be responsible to hire 8 positions and administer a funding change for the Organizational Development Specialist, a critical existing position that supports foundational work related to population health, and the quality and performance of the public health department. The CDC funding for the Organizational Development Specialist ends in December, 2014. Continued funding is available for this position through PHHS block grant until October 1, 2015. This opportunity became available this spring as part of the one-time supplemental PHHS block grant funds provided to the state. Given this, we propose to use SIM funds beginning 10/1/2015 and have adjusted the budget accordingly.

The other positions will be prioritized as follows:

- Priority 1: Physician 2, Health Program Associate, Secretary 2, Epidemiologist 3 (SIM/DPH): This will establish and staff a DPH SIM office that will do the majority of work for the Population Health Plan.
- Priority 2: Epi 2 (BRFSS), Health Program Associate (Local Health), Prevention Service Coordinator (SIM/DPH). These positions are supportive to contractor work or positions identified above.
- Priority 3: Epi 3 (BRFSS). Position and funding is needed beginning in Year 2.

Agency and program specific orientations, and mentoring of job duties will be provided by hiring supervisors. Attendance at specific national meetings and conferences will supplement the orientation and mentoring by keeping new staff current with technical skills, and engaged with acquiring knowledge on trends and innovations in health system transformation.

Public health agency program specific orientations will be provided by supervisors. Attendance at specified national meetings and conferences are included for the Physician 2, and Epidemiologist 3 and 2 to assist these positions with ongoing knowledge in key programmatic areas as BRFSS, data analysis, health equity, and the evidence base.

DSS – HIT - UCHC: UCHC will hire staff to support HIT initiatives during the first 4 months of the grant. At this time we do not anticipate any special training for these staff besides general orientation to the SIM initiative and general overview of the inter-relationship between SIM funded initiatives and Connecticut's HIT strategic and operational plan.

11. Describe recent or developing legislative and policy initiatives underway in the State that may enhance the proposed health care transformation efforts. Describe how these initiatives would be integrated into the proposal.

See Pages 23 to 26 of the Revised Project Narrative.

Response: Pages 23 to 26 of our Project Narrative describe a broad array of legislative and policy initiatives that align with our objectives under SIM, and which will create opportunities for integration with our ongoing SIM program design and implementation activities. Several examples are as follows:

- Public Act (PA) 14-217 established funding for the PMO, which enables the PMO to play an ongoing role in the coordination and integration of state agency, provider, payers, and stakeholder activities, including beyond the period of performance for the SIM grant.
- PA14-148 requires DPH to develop a chronic disease prevention and reduction plan consistent with the Innovation Plan, which provides the opportunity to integrate DPH's overarching chronic disease prevention and reduction plan with specific systemic changes in community governance, accountability and health care financing as envisioned as part of the Health Enhancement Community concept. SIM will bring greater focus on maximizing the use of public and private health financing levers to reward providers and other community entities for achieving population health goals.
- PA13-247 established the All-Payer Claims Database (APCD), which will be the primary source for data to enable evaluation of SIM related care delivery and payment reforms.
- PA14-168 helps ensures competitive healthcare markets by requiring Attorney General notification and the submission of information regarding material changes to the business or structure of physician group practices. This law also requires annual filing of hospital, system, and physician group affiliation to enable the state to better monitor the impact on competition and price as providers organize and consolidate to assume accountability under SIM related payment reforms. The inclusion of new certificate of need requirements regarding transfers of ownership of certain physician group practices to any entity other than physicians or physician groups will provide the state with additional control over such consolidation. These activities are important in light of evidence nationally that the gains in waste reduction and quality achievable in larger systems (and enabled by CT's SIM initiative) can be countered by reductions in competition and associated increases in pricing.
- PA14-12 permits APRNs who have been licensed for at least three years to practice independently. The implications of this change will be considered by the Practice Transformation Task Force as it considers the role of APRNs within health care teams and the context of medical home recognition.
- PA14-211enables licensed behavioral health clinics to provide "off-site" services in physician offices and other healthcare settings, removing a longstanding barrier to the integration of primary care and behavioral health. This new flexibility will be a consideration for the Practice Transformation Task Force in the development of integrated behavioral

health standards and will provide additional flexibility in our efforts to provide technical assistance for practice transformation in this important area.

- PA 14-217 which transfers responsibility for HIT and the Health Information Exchange (HIE) coordination to DSS will better enable the integration of SIM HIT initiatives, especially as it pertains to information exchange and analytics, and with DSS HIT initiatives within Medicaid such as the administration of the EHR incentive program.
- PA14-145 requires that consumers be informed of hospital facility fees, which will empower consumers to take cost into consideration when making decisions about where to go for care.
- New requirements for online license renewals for physicians, dentists, and APRNs is enabling us to integrate workforce survey questions so that we can more easily gather timely information about capacity distribution and changes in provider capabilities (e.g., EHR adoption, extended hours, etc.). DPH and the PMO are currently developing physician survey questions. PMO workforce analytic resources will enable the analysis of this data to inform our primary care investments and track progress over time.

12. Provide an example of an innovative financing strategy that will be used to fund Health Enhancement Communities.

See Page 3 of the Revised Project Narrative.

Response: In 2018, informed by the results of the return on investment analysis, the Population Health Council will be tasked with making a recommendation on mechanisms to finance Health Enhancement Communities. One or a combination of the following strategies will be considered.

- The initial phase will include seeking State Appropriations for startup costs in SBY 18/19 (see response to question 1a) and additionally establish a dedicated wellness trust fund to capture a portion of the anticipated savings. Savings could potentially be captured by a small assessment on entities realizing or most likely to realize savings from the implementation of HECs (e.g. payers, healthcare organizations). Alternatively, entities realizing such savings may realize a business-case and be willing to make up-front and ongoing financial commitment to the wellness trust fund. This assumes that shared savings rewards will be linked to measured community-wide performance in areas that are a direct focus of HEC efforts.
- Opportunities to align grant funded programs around a HEC will be sought. For example, Stamford, CT has already harnessed HUD and EPA resources to help fund a Health and Wellness District initiative http://vitastamford.com/about-vita/. In addition, CDC funds numerous disease prevention and control initiatives, many administered by DPH and implemented at the local level (e.g. healthy food retail, local active transportation initiatives, medication therapy management) which offers opportunity to align programs around the concept of HEC.
- Finally, The Department of Social Services will review all available options for State Plan and waiver authority in support of HECs. For example, by enabling reimbursement for community health workers and bundled payments for trauma-informed wrap-around interventions for children and families.

13. Provide an example of a "multi-sector governance solution" that would constitute a Health Enhancement Community.

See Pages 4 of the Revised Project Narrative.

Response: A variety of governance solutions will be considered by the Population Health Council during the HEC design phase in years 2-4. The planning process will include a survey of emerging national models such as those in use in Washington (Accountable Care Organizations), Oregon (Coordinated Care Organizations), and Minnesota (Hennepin County). Additional examples include:

- Lead Fiduciary Agent Model: Beginning in 2011, DPH has administered the CDC's Community Transformation Grant in five of CTs eight counties. Because CT lacks a county government structure, one health district from each county was charged with fiduciary oversight and program coordination through establishing county-wide multi-sector, community coalitions and developing and executing local plans to implement policy, environmental, and infrastructure changes related to the CTG strategic areas (smoking, healthful living and preventive services). Such a coalition-based model could be focused and modified to serve the governance needs of HECs. Similar approaches are being employed by Maryland's Health Enterprise Zone initiative and lessons learned from that initiative are anticipated to be available to inform HEC governance design.
- Health Neighborhood Model: In support of implementing the CMMI Demonstration to Improve Care for Medicare-Medicaid Enrollees, DSS has conceptualized new, multi-disciplinary provider arrangements called "Health Neighborhoods" (HNs). These provider networks will be supported in data analytic and other functions by the Medicaid medical Administrative Services Organization (ASO), and will formally organize across provider types through care coordination contracts, electronic means and a learning collaborative in furtherance of holistic and coordinated support of members' health needs. This network approach represents another kernel that could be expanded to provide a multi-sector governance solution in support of HECs.

14. Please identify differences between proposed Prevention Service Centers and Health Enhancement Communities. Who will staff Prevention Service Centers?

See Page 5 of the Revised Project Narrative.

Response: Prevention Service Centers are community-placed organizations that would meet criteria for the provision of evidence-informed, culturally and linguistically appropriate community prevention services. Prevention Service Centers may be new or existing local organizations, providers (e.g., FQHCs), non-profits or local health departments. Prevention Service Centers will initially focus on environmental quality issues in homes and promoting positive health behavior (e.g. asthma home environmental assessments, diabetes prevention programs, and falls prevention). Prevention Service Centers will foster alignment and collaboration between primary care providers, community-based services and State health agencies. Their workforce will include existing workers providing similar services (e.g. local health department staff, Area Agencies on Aging, FQHC staff) and the emerging cadre of community health workers envisioned as part of our healthcare workforce development strategy.

Building upon ongoing efforts by the public health and local communities, the SIM proposes a new initiative to create Health Enhancement Communities (HECs). The purpose of these newly created

HECs will be to intensify and coordinate community resources to improve health in areas with the highest disease burden, worst indicators of socioeconomic status and pervasive and persistent health disparities. The Health Enhancement Communities (HECs) will be collaborative multi-sector partnerships—alliances among people and organizations from multiple sectors working together to improve conditions and outcomes related to health and well-being of entire communities. This model is well-established and variations of the model are being implemented with respect to community health interventions in numerous states, including Connecticut. We anticipate that Prevention Service Centers would be among the multi-sector participants.

One example of an effective collaborative partnership, referenced previously in the response to question #12, is a health and wellness district jointly sponsored by Charter Oak Communities, City of Stamford and Stamford Hospital. The vision is not only to revitalize the economic health and well-being of Stamford's West Side residents but also to ensure a health and wellness destination that can improve the quality of life for the entire city. Areas of focus include expanding access to healthier food, fitness opportunities, and preventive health and medical care as well as job training and workforce development. Informed by a local Community Health Needs Assessment (CHNA) and a collaborative strategic planning process, the initiative is well underway and has achieved a number of accomplishments.

15. *Please clarify the fee to be imposed on providers to fund the administration and conduct of the care experience survey and the mechanism for obtaining this fee.

See Pages 37 to 40 of the Revised Project Narrative.

Response: All of Connecticut's payers will require a statistically valid and sufficient consumer survey as a condition for participating in a value-based payment arrangement as of the 2016 contract year, using a care experience survey tool recommended by the Quality Council and approved by the Healthcare Innovation Steering Committee. The results of such survey will be used to assess the performance of each Advanced Network or FQHC (collectively referred to here as provider organizations) for the purpose of determining qualification to receive shared savings. The sample will be drawn from each entity's attributed patients, without regard to payer or source of coverage, except that in the initial years, we will oversample for Medicaid in order to quantify the Medicaid/commercial health equity gap as it pertains to care experience.

The per provider organization cost of administering a statistically sufficient CAHPS survey (assuming that is the measure selected) depends on the number of primary care clinicians employed by or affiliated with the provider organization for the purpose of performance accountability and the methods that are used. See Table 6 for NCQA's information detailing the sample size required as it relates to the number of primary care clinicians.

Table 6

Sample Sizes

Number of Clinicians	Sample Size
1	128
2-3	171
4-9	343
10-13	429
14-19	500
20-28	643
29 or more	686

Table 7 presents the approximate cost per provider organization based on the required sample size, using an NCQA certified vendor and methods. We anticipate that nearly all of these provider organizations are comprised of greater than 29 clinicians placing them in the largest survey class.

Table 7

Care Experience Survey		
Cost per provider organization		
Sample Size	Low Range ($5/completed)	High Range ($10/completed)
128	$ 640	$ 1,280
171	$ 855	$ 1,710
343	$ 1,715	$ 3,430
429	$ 2,145	$ 4,290
500	$ 2,500	$ 5,000
643	$ 3,215	$ 6,430
686	$ 3,430	$ 6,860

We assumed that we would survey 45 provider organizations in 2016 (for 2015 baseline) and 45 provider organizations in 2017 (for 2016 performance year at $6860 per provider). This is double the above "low range" cost, which provides for Medicaid over-sampling. We assume that the annual ongoing fee charged to entities for statewide administration of their survey would remain at this level as long as we continue to include Medicaid over-sampling.

For the first two years (2015 baseline, and 2016 performance year), the state has proposed to use SIM funding to subsidize the cost of the survey. The PMO will co-source the conduct of the survey on behalf of all payers and provider organization participating in SSP arrangements. We believe that combining the purchasing power in this way will reduce the cost per completed survey. As of the 2017 performance year, each provider organization will have the option to arrange for and finance

the care experience survey themselves, provided they use the survey tool and methods approved by the Steering Committee, and to have their performance reported to the PMO and each payer.

Pending review of our proposed approach with the Quality Council, the PMO intends to co-source the conduct of the survey using an NCQA certified vendor and methods. Beginning with the 2017 performance year, the vendor will be expected to administer the collection of provider organization fees to support the administration of the survey in early 2018. In the third quarter of 2017, the PMO will solicit from payers a list of provider organizations participating in SSP arrangements. The vendor will contact each provider organization giving them the option of participating in the PMO administered survey process. The provider organization will be asked to pay a fee and sign an agreement. The vendor will send the signed agreements to each payer in the fourth quarter of 2017 soliciting a list of attributed beneficiaries. In the first quarter of 2018, the vendor will undertake the survey, compile results into a report, and provide the report to the PMO and each payer for use in the administration of their shared savings payment arrangements. Provider organizations that do not enter into an agreement with the PMO's vendor will be required by payers to provide a qualifying survey in order to receive a shared savings distribution.

16. Please describe the timeline for operationalizing the CT Teaching Health Center Coalition and the Community Health Center Association of CT to develop a primary care medical residency program.

See Page 14 of the Revised Project Narrative.

Response: The CT Teaching Health Center Coalition already exists, being comprised of the executive directors of 8 of CT's 14 FQHCs. All these executive directors are members of Community Health Center Association (CHCACT) board, which this coming year is being chaired by Jim Maloney who is executive director of Greater Danbury Community Health Center, CT's first teaching health center. On September 8, Staywell Health Center in Waterbury in conjunction with Griffin Hospital will announce a second track of Danbury's internal medicine residency program. Our objective is residency programs in several primary care disciplines. In addition to our existing internal medicine residency program, we are currently looking into developing programs for family medicine and children's dental medicine, but we may ultimately consider other disciplines as well. Each residency program will include multiple health centers. We anticipate individual health centers may participate in more than one residency, and we anticipate that all the residency programs will be coordinated with each other. We seek a statewide network. We expect to approach HRSA for additional support in 2015.

17. The stated goal of the CCIP is to spur investment & accelerate advancement in 11 priority areas. According the proposal, the State plans on doing this by hiring vendors to provide targeted technical assistance (TTA) across these 11 priority areas. Please clarify how many vendors are anticipated to provide this TTA, and how the TTA is expected to spur investment and accelerate advancement.

See Pages 11 to 12 of the Revised Project Narrative

Response: The state will procure one or two vendors to provide practice transformation services within the Community and Clinical Integration Program (CCIP). We anticipate that one vendor may be sufficient to administer the CCIP for both FQHCs and Advanced Networks; however, we will consider an additional vendor if a second vendor is needed for reasons of bandwidth (i.e., the capacity to engage multiple providers simultaneously) or if it appears that a second vendor is needed

with specific experience and expertise in working with FQHCs and their associated vulnerable populations and organizational structures. In addition, we expect that these practice transformation vendors will subcontract with 8-10 subject matter experts who have substantial expertise and experience with the 11 TTA topic areas.

The CCIP program will spur investment and accelerate advancement in two ways. The CCIP program will be offered to Advanced Networks and FQHCs that successfully compete to participate in the Medicaid QISSP program. Selection criteria will include a requirement that respondents commit to investing in the development of organizational capabilities, with attendant timeframes and milestones, during the performance period. Thus, the RFP competition will spur commitments to invest. In addition, the TTA will provide technical resources to accelerate advancement, beyond the level of performance these providers would otherwise achieve if they did not receive such assistance and did not commit to necessary investments.

The Innovation Awards program (part of the CCIP) will also, through a competitive process, require a commitment to invest in the development of organizational capabilities, with attendant timeframes and milestones, during the performance period. We will determine during the next phase of planning whether we will require specific in-kind investments in order to qualify for the awards. In summary, the Innovation Awards process will spur investments through competition and it will accelerate advancement through the provision of grant resources and a structured grant administration process.

18. The Budget Narrative section of your proposal indicates two learning systems will be created: one each for Advanced Networks and FQHCs. However, the Project Narrative indicates that the PMO will establish three learning collaboratives: one for practices in the AMH glide path, one for FQHCs and one for Advanced Networks participating in MQISSP. Please clarify.

See Pages 25 to 26 of the Revised Budget Narrative.

Response: Both documents are correct; however, the third learning collaborative for AMH is cited separately in the Budget Narrative. The PMO will establish three learning collaboratives. This includes one learning collaborative for practices participating in the AMH glide path. It also includes one for FQHCs and one for Advanced Networks participating in MQISSP *and delivered as part of the CCIP*. We have highlighted references to the first learning collaborative on page 25 of the Budget Narrative and all references to the two additional learning collaboratives as part of the CCIP, on page 26 of the Budget Narrative.

19. The Budget Narrative section of your proposal indicates "Innovation awards for MQISSP participating FQHCs and Advanced Networks will be available as competitive awards in the 9 targeted technical assistance areas." However, in the Project Narrative, you indicate there are 11 targeted TA areas (9 +2 additional target areas for FQHCs). Please clarify.

See Page 26 of the Revised Budget Narrative

Response: The reference to 11 targeted TA areas (9 +2 additional target areas for FQHCs) in the project narrative is correct. We have amended and highlighted the Budget Narrative on page 26 accordingly.

20. Activities in the Operational Plan regarding Inter-professional Education do not align with the Project Narrative. In the Operational Plan, activities involve informational sessions, surveys assessing interest, and meetings with prospective partners. The Project Narrative indicates that AHEC will work with all CT health professions schools/programs to develop & incorporate inter-professional, team-based curricula and sponsor IPE training sites throughout the state. Please clarify.

See Pages 12 to 13 of the Revised Project Narrative.

Response: In our State Healthcare Innovation Plan, the Connecticut Service Track (CST) came within a broader IPE initiative. CST is what the Operations Plan describes, and is what we are seeking funding to initiate. The Project Narrative errs in referring to the broader IPE initiative, which will be orchestrated by the Workforce Development Council, and for which we are not seeking funding. The narrative should read:

"Inter-professional education (IPE): The Area Health Education Center (AHEC) will invite all CT health professions schools/programs to participate in the Connecticut Service Track (CST), and will work with them to develop and incorporate inter-professional, team-based curricula and sponsor IPE training sites throughout the state in accordance with the CST model."

The proposed Connecticut Service Track (CST) is an expansion of our nationally acclaimed Urban Service Track. The Urban Service Track serves Connecticut's disadvantaged urban communities and includes UConn's medical, nursing, pharmacy and social work schools plus Quinnipiac's physician assistant program. CST will serve disadvantaged populations throughout Connecticut, and our aim is to include all of Connecticut's professions schools and primary care residency programs.

All Urban Health Scholars participate in a two-year curriculum that complements the existing curricula in the six schools and focuses on 11 competencies. Faculty includes university and community health center clinicians, patients and other community partners. UST explores the 11 competencies in terms of the needs of a number of vulnerable populations: children/youth, the elderly, individuals with HIV/AIDS, incarcerated and ex-offender populations, immigrants/refugees, disparity populations, veterans and people who abuse substances. Students participate in problem-based learning activities that include clinical skills and case studies.

In addition, attention is paid to the skills needed for interprofessional teamwork. There are formal quarterly learning retreats, community outreach activities, community based research, advocacy and leadership education. Critical to the success of UST is the opportunity for students to apply knowledge and skills gained in real world settings. This is done through a variety of community outreach activities that focus on health promotion, education, health risk screenings and health careers awareness for individuals from underrepresented backgrounds.

Mentors drawn from both the participating schools and the community instruct students in leadership, effective management of a team, working with team members with different skills and education, effective utilization of community partners and preceptors, and grant writing.

UST has been effective at persuading students to go into primary care. In 2013, students who have graduated from UST were surveyed to determine whether the program positively impacted their desire to work in primary care and with medically underserved communities. 59.6 percent reported that it had contributed to their choice of primary care, and 56.9 percent reported that it contributed to their desire to work in medically underserved communities.